Tribunals Ontario | **Tribunaux décisionnels Ontario**

Licence Appeal Tribunal | Tribunal d'appel en matière de permis

Citation: Heath v Certas Home and Auto Insurance Company, 2026 ONLAT 25-009814/AABS

File Number: 25-009814/AABS

In the matter of an application pursuant to subsection 280(2) of the Insurance Act, RSO 1990, c I.8, in relation to statutory accident benefits.

Between:

David Heath

Applicant

and

Certas Home and Auto Insurance Company

Respondent

DECISION AND ORDER

ADJUDICATOR: **Tami Cogan, Member**

APPEARANCES:

For the Applicant: Lane Foster, Counsel

For the Respondent: Jonathan Schrieder, Counsel

HEARD: **July 6, 7, 8, 9, and 10, 2026 by video conference**

OVERVIEW

[1] David Heath, the applicant, was involved in an automobile accident on October 16, 2022, and sought benefits pursuant to the *Statutory Accident Benefits Schedule* - Effective September 1, 2010 (including amendments effective June 1, 2016) (the "*Schedule*"). The applicant was denied benefits by the respondent, Certas Home and Auto Insurance Company, and applied to the Licence Appeal Tribunal - Automobile Accident Benefits Service (the "Tribunal") for resolution of the dispute.

[2] The applicant's accident involved a single all terrain vehicle. His injuries included a complex fracture to his left ankle, which required fusion. He claims his injuries prevent him from performing the physical tasks of his pre-accident self-employment and the loss of his independence has caused psychological injury. He seeks a catastrophic impairment designation based on a combination of his physical and psychological injuries (criterion 7) and based mental and behavioural functional limitations (criterion 8). He further seeks income replacement benefits, attendant care benefits, and rehabilitation benefits. The respondent contends that he is capable of employment based on his education, training and experience, and that his psychological condition does not meet the threshold for a catastrophic impairment, and he has exhausted the $65,000.00 medical and rehabilitation benefits available for non-catastrophic impairments.

ISSUES IN DISPUTE

[3] The issues in dispute are:

1. Has the applicant sustained a catastrophic impairment as defined by the *Schedule*?

2. Is the applicant entitled to an income replacement benefit in the amount of $400.00 per week from March 31, 2025, to present and ongoing?

3. Is the applicant entitled to attendant care benefits in the amount of $2,672.18 per month from June 18, 2025, to present and ongoing?

4. Is the applicant entitled to $6,255.64 for assistive devices, proposed by Headwaters Occupational Therapy Services, in a treatment plan/OCF-18 (“plan”) dated September 11, 2023?

5. Is the applicant entitled to $4,405.00 for social worker services, proposed by FunctionAbility Rehabilitation Services, in a plan dated August 16, 2024?

6. Is the respondent liable to pay an award under s. 10 of Reg. 664 because it unreasonably withheld or delayed payments to the applicant?

7. Is the applicant entitled to interest on any overdue payment of benefits?

[4] At the start of the hearing, the applicant withdrew the treatment plans listed as issues 3.ii., and iii., 5, and 6 in the case conference report and order (CCRO).

[5] At the start of the hearing the parties agreed to amend the starting date for the time period in dispute for the income replacement benefit from April 12, 2024, to March 31, 2025, as listed above.

RESULT

[6] For the reasons that follow, I find:

1. The applicant has not sustained a catastrophic impairment as defined by the *Schedule*.

2. The applicant is not entitled to an income replacement benefit.

3. The applicant is not entitled to attendant care benefits.

4. The applicant is not entitled to $6,255.64 for assistive devices, proposed in a plan dated September 11, 2023.

5. The applicant is not entitled to $4,405.00 for social worker services, proposed in a plan dated August 16, 2024.

6. The respondent is not liable to pay an award under s. 10 of Reg. 664.

7. Interest is not owing.

PROCEDURAL ISSUE

Applicant's Motion for a Production Order, or Exclusion of IE Reports

[7] On Friday, July 3, 2026, at 4:55pm the applicant served and filed a notice of motion seeking a production order for the clinical notes and records, and draft reports of the Insurer Examination (IE) assessors. Or in the alternative, an order for the exclusion of the IE reports. The orders were sought on the grounds that the respondent had not disclosed the clinical notes and records, and draft reports of the assessors, as agreed to at the case conference, and it is in breach of the CCRO. He submits that the reports were released on March 27, 2026, and the respondent has not provided proof that the documents were requested from the assessors, and that without these documents he has not been able to properly prepare cross-examination of the witnesses.

[8] The respondent submits that the motion should not be heard on the grounds of its untimely service because the respondent has not had sufficient time to prepare a response. In the alternative, the respondent submits that it has not breached the CCRO because the IE assessments had not yet been completed at the time of the case conference, and the consent to exchange documents only applied to documents that existed at that time, which these documents did not. Further, the respondent submits that the relief sought by the applicant is disproportionate to the alleged breach.

[9] I did consider that the applicant followed Rule 15.1, pursuant to the *Licence Appeal Tribunal's Rules*, 2023 (the Rules"), in filing his motion, therefore I heard submissions from both parties.

[10] I do agree with the respondent that it did not breach the CCRO because the documents being sought did not exist at the time of the case conference and were therefore not part of the identified documents the respondent agreed to exchange within 45 days of the case conference.

[11] Pursuant to Rule 9.2, prior to making a request for a production order, a party must make reasonable efforts to obtain a document or thing without a production order. I accept that the applicant made initial effort when asking the respondent for the disclosure at the case conference. However, I find that by the applicant's own submissions, it was not until July 1, 2026, that he had corresponded with the respondent seeking the disclosure. This is more than three months after receipt of the IE reports, and two business days prior to the hearing. I have not heard submissions as to why the applicant waited until the eve of the hearing to request a production order, and I am not satisfied that reasonable efforts were made.

[12] I agree with the respondent that materials intended to be relied on must be produced 21 days prior to the hearing. I accept that the applicant is also seeking leave to rely on any documents the Tribunal orders to be produced. However, I find the motion is untimely because if the documents could be produced, it leads to a question of delay of these proceedings.

[13] I also agree with the respondent that the relief sought for an order excluding the IE reports is disproportionate. The applicant has had the final reports, and any questions that speak to the weight of the experts' conclusions are best addressed in cross-examination, however the applicant chose to not summons the experts.

[14] I am denying the applicant's motion for a production order, and the exclusion of the reports. The respondent may rely on the IE reports. I encourage the parties to make submissions as to weight in their closing arguments.

ANALYSIS

Catastrophic Impairment ("CAT")

[15] I find that the applicant has not sustained a CAT impairment as a result of the accident.

[16] On June 19, 2025, the applicant applied to the respondent for a determination that his accident-related impairments meet the definition of a CAT impairment under the *Schedule*. The current dispute involves whether he sustained a CAT impairment pursuant to Criteria 7 and 8. I will first discuss whether the applicant qualifies under Criterion 7.

CRITERION 7

[17] I find that the applicant has not sustained a combined physical and behavioural catastrophic impairment under criterion 7 of the *Schedule*.

[18] In order to qualify for CAT under Criterion 7, the applicant must prove that he has a combination of physical and psychological impairment ratings from medical professionals that meet the 55% whole person impairment ("WPI") threshold according to *American Medical Association's Guides to the Evaluation of Permanent Impairment* ("Guides"). The psychological impairment, excluding traumatic brain injury, is determined in accordance with the rating methodology in Chapter 14, Section 14.6 of the Guides, 6th edition, 2008. The physical impairment or combination of physical impairments ratings are determined in accordance with the Guides, 4th edition.

[19] The applicant submits he has an overall WPI of 55% under Criterion 7, and meets the 55% threshold for CAT impairment. He relies on the executive summary report dated

June 4, 2025, of Dr. Tajedin Getahun, orthopaedic surgeon. Dr. Getahun rated the applicant with a 20% WPI, which included ratings for left lower extremity, lumbosacral spine, scarring, and medication. Dr. Santo Basile, neurologist rated the applicant with 6% WPI, which included sleep, migraine headaches, and tension headaches. Dr. John Gilman, neuropsychologist rated the applicant as having 40% WPI in mental/behavioural.

[20] The respondent submits that the correct overall WPI is 40%, which does not meet the threshold for CAT impairment. The respondent relies on the orthopaedic evaluation of Dr. Omar Dessouki, orthopaedic surgeon who rated the applicant with a 33% WPI, which included ratings for left lower extremity, scarring, and medication. Dr. Garry Moddel, neurologist rated the applicant with 0% WPI neurological systems. Dr. Sadiq Hasan, psychiatrist rated the applicant as having 10% WPI in mental/behavioural. The respondent submits the applicant has not sustained a catastrophic impairment under criterion 7.

[21] The following chart summarizes the WPI% ratings assigned by each parties' assessors under Criterion 7.

AMA Guides 4th Ed.	**Applicant's Ratings**	**Respondent's Ratings**	**Tribunal's Ratings**
Physical Impairments			
Chapter 2: Medication	**3%**	**2%**	**3%**
Chapter 3:	**15%**	**25%**	**15%**
Left Lower Extremity Impairment	**10%**	**25%**	**10%**
Leg length discrepancy Table 35	0%	5%	0%
Gait Derangement Table 36	0%	15%	0%
Muscle Atrophy Table 37	0%	10%	0%

Manual Muscle Testing Table 38	0%	0%	0%
Range of Motion Table 42	6%	12%	6%
Fixed/Ankylosed Table 57	4%	10%	4%
Diagnosis Based Estimate Left Ankle Table 64	0%	8%	0%
Spinal Lumbosacral Spine Impairment	**5%**	**0%**	**5%**
Chapter 4:	**6%**	**0%**	**3%**
Migraine Headaches	2%	0%	0%
Tension Headaches	1%	0%	0%
Sleep Impairment Table 6	3%	0%	3%
Chapter 13: Scarring Table 2	**3%**	**9%**	**3%**
Total WPI **Combined Values Chart:**	**25%**	**34%**	**22%**
AMA Guides 6th Ed. Chapter 14.			
Mental / Behavioural Impairments	**40%**	**10%**	**10%**
BPRS	-	15%	
GAF	-	10%	
PIRS	-	10%	
TOTAL CRITERION 7 COMBINED RATING			
Total WPI Criterion 7 Combined Values Chart:	**55%**	**40%**	**30%**

Medication

[22] The Guides direct that a rating for adjustment for effects of treatment, including medication, is entirely discretionary. A physician may choose to increase the impairment estimate by a small percentage of 1% to 3% WPI. Dr. Dessouki assigned a 2% WPI for medication use, including CBD and THC. Dr. Getahun assigned a 3% WPI for medication use including Advil and cannabis. While both assessors have provided a rating, it is unclear as to how each reached their assigned rating. I find a 3% WPI is appropriate because Dr. Basile, neurologist opined that the applicant's use of medication for pain has resulted in headaches caused by medication overuse.

Lower Extremity

[23] **Limb Length Discrepancy:** Dr. Getahun assessed that there was no appreciable leg length discrepancy and gave a rating of 0% WPI. This is in contrast to Dr. Dessouki's assessment that the applicant has a leg length discrepancy of 3 cm on the left side, and assigned a 5% WPI. The Guides recommend that a teleroentgenography be used for estimating this impairment, however neither assessor identified the methodology used for their determination. I find that the evidence is inconsistent regarding leg length discrepancy and does not support the rating assigned by Dr. Dessouki. Further, in the physiatry assessment report of Dr. Ismail dated April 14, 2025, the applicant described his leg length discrepancy as being one inch, but that his half inch heel rise in his left shoe improved his ambulation. The discrepancy is also partly attributed to a previous left femoral fracture to the left leg. I find that the evidence before me regarding the applicant's leg length discrepancy is highly inconsistent and is not reliable for a WPI rating. I find the appropriate rating is 0% WPI.

[24] **Gait Derangement:** The Guides direct that gait derangement is a component of many different types of lower extremity impairments. Gait derangement estimates may serve as a general guide for estimating lower extremity impairments, and that the rating should stand alone – and not be combined with other ratings under section 3.2, and further, more specific methods should be used in estimating impairments, unless the gait

disturbance best reflects the overall impairment. Dr. Getahun's rating of 7% is based on the applicant's altered gait with shortened stance phase and osteoarthritis. However, in his executive summary, Dr. Getahun does not provide a rating. I am not persuaded by Dr. Dessouki's rating of 15% WPI, because he based the rating on the applicant's part-time use of a cane for support, yet in his report it is indicated that the applicant does not use a cane. This was corroborated by the applicant's own testimony that he does not use a cane. Further, Dr. Dessouki combines the gait derangement with all other parts of s. 3.2 that he assessed, which artificially inflated the overall lower extremity rating. I find the appropriate rating is 0% WPI because in accordance with the Guides, more specific methods should be used in estimating impairments, as set out below.

[25] **Muscle Atrophy:** Dr. Getahun does not assess a rating under this criterion. Dr. Dessouki assigned a 10% combined WPI rating for muscle atrophy of 4cm in the applicant's thigh, and 4cm in the applicant's calf. I find Dr. Dessouki's assessment is not persuasive because it is contradicted by the neurological assessment report of Dr. Basile, which indicates that there is no evidence of muscle atrophy or wasting. However, Dr. Farooq Ismail, physiatrist does observe "significant atrophy of the calf musculature on the left side, but does not provide any further details to quantify his observation. However, in spite of the contradictions in expert observations, I find that the WPI rating is 0% because the Guides direct that muscle weakness or atrophy is included in the diagnosis-related estimates (below). Further, the Guides direct that muscle atrophy should not be estimated if a rating for range of motion is being given. Therefore, a rating for muscle atrophy is duplicative. I find the appropriate rating is 0% WPI.

[26] **Manual Muscle Testing:** Dr. Dessouki does not assess a rating under this criterion. Dr. Getahun assessed a 5% WPI for weakness of ankle dorsiflexion, grade 4. However, in his executive summary, Dr. Getahun does not provide a rating. I find the appropriate rating is 0% WPI.

[27] **Range of Motion:** Dr. Getahun provides ratings of 2% for restricted range of motion of the great toe; 2% rating for restricted motion of the lesser toes; and 2% for the subtalar joint. Dr. Dessouki assigned a 12% WPI for range of motion in the left ankle that

had been fused. I am not persuaded that it is appropriate to estimate the range of motion of a fused joint, that is by definition the equivalent of an ankylosed joint, if a rating is also being given for joint ankylosis. Therefore, I find Dr. Getahun's range of motion ratings of 6%, is appropriate.

[28] **Joint Ankylosis:** Dr. Getahun provided a rating of 4% WPI based on the left ankle being fused in a neutral position. Dr. Dessouki assigned a WPI of 10% based on the ankylosed valgus position of 15 degrees. I find that this rating is duplicative of the diagnosis-based estimate ratings that Dr. Dessouki provided because the Guides are clear that only one approach of either diagnostic or examination should be used, for each anatomic part. The Guides further direct that a malunion of a fracture should be estimated according to the diagnosis (below). I have also considered that the ankle was fused in a neutral position, not in the valgus position, and I am not persuaded that the 10% rating is appropriate. I find the appropriate rating is 4% WPI.

[29] **Diagnosis Based Estimate (DBE):** Dr. Getahun does not assess a rating under this criterion. Dr. Dessouki assigned an 8% WPI for the left ankle according to Table 64 of the Guides. Dr. Dessouki does not provide an explanation as to how he reached the rating. However, I accept this rating because according to the Guides an 8% WPI would be the result of an intra-articular fracture of the ankle with displacement. Therefore, I find that the DBE is the appropriate approach to rating the lower extremities and the rating is 8% WPI.

[30] The Guides direct that when two ratings are possible, the higher of the two ratings is to be used. Therefore, I accept Dr. Getahun's 10% rating under lower extremity, over Dr. Dessouki's 8% diagnosis based estimate rating.

Spine

[31] **Lumbosacral:** Dr. Dessouki did not provide a rating because the applicant did not have any complaints at the time of the assessment, and there were no objective findings. Dr. Getahun assessed a 5% WPI based on a DRE II, Minor Impairment. I find

5% WPI is appropriate because the Guides direct that muscle guarding can be intermittent or continuous, therefore I find that Dr. Dessouki's negative findings do not undermine Dr. Getahun's objective findings of muscle guarding on the right side. Furthermore, the applicant testified that his lower back was sore due to his gait compensating for his left ankle, which he consistently reported to Dr. Basile, and Dr. Ismail. I find that 5% WPI is an appropriate rating.

Nervous System

[32] **Headaches:** On assessment, Dr. Basile diagnosed posttraumatic headaches, including tension type headaches and chronic daily medication overuse headaches, and migrainous features. He assessed a 2% WPI for migraine headaches, and a 1% WPI for tension headaches. I find that at section 4.5 of the Guides it direct for an assessment and rating of the organ system that causes the pain, because pain is considered in, and the WPI rating allows for, the pain that may accompany the impairing condition. Dr. Basile has not identified or assessed the organ system that results in the applicant's headaches. I find headaches in and of themselves do not attract an impairment rating. In the absence of an identified impairment of the relevant organ system, the Guides do not support assigning a separate WPI rating for headaches as a symptom. Further, I find a rating for a headache resulting from medication overuse would be duplicative of the rating already considered for treatment / medication, under Chapter 2 of the Guides.

[33] **Sleep Disturbance:** Dr. Dessouki does not provide a rating on this criterion. Dr. Basile assessed a WPI of 3% for sleep disturbances due to headaches, pain and anxiety. The Guides allow for a WPI rating between 1 – 9% for reduced daytime alertness with sleep pattern such that patient can carry out most daily activities. I accept this 3% rating because I heard testimony from Maria Paulsson, occupational therapist, who recommended an adjustable bed and mattress to allow the applicant to re-position himself and reduce pain associated with his ankle that was waking him at night. Further, the applicant's complaints of attention, concentration impairments, partially due to fatigue, have been consistent and warrant an impairment rating.

Skin

[34] **Scarring:** Dr. Getahun assessed the applicant's scar as disfiguring and rated it as a class I impairment, assigning a 3% WPI. Dr. Dessouki assessed the applicant's scar as a 9% WPI. I give this rating little weight because Dr. Dessouki's report is internally inconsistent. In his objective findings he notes that the applicant does not have tenderness at the scar. Yet in the explanation of his WPI rating he states that the scar results in significant pain, sensitivity, and loss of sensation. I find Dr. Ismail's report is consistent with Dr. Dessouki's objective findings because Dr. Ismail recorded that the scars are well-healed with no tenderness on palpation. I find that the applicant's scar does not attract a 9% rating because at section 13.2 the Guides direct that activities of daily living should be the primary consideration, as well as frequency and intensity of signs and symptoms, and treatment required. The assessors agree that there is no functional impairment as a result of the scar, which does not require treatment. For these reasons I find the lower 3% WPI is appropriate.

Mental / Behavioural Impairments

[35] The *Schedule* directs that Chapter 14 of the 6th Edition is to be used to determine the mental/behavioral impairment rating for criterion 7. This requires assessment using the Brief Psychiatric Rating Scale (BPRS), the Global Assessment of Functioning (GAF), and the Psychiatric Impairment Rating Scale (PIRS). The median of the three scores is then used as the WPI percentage rating.

[36] Dr. Hasan followed the Guides and assigned a 10% WPI rating. The applicant's score on the BPRS was 42, which is equivalent to 15% in accordance with Table 14.9. The applicant's resulting score on the GAF was 53; moderate symptoms or moderate difficulty in social, occupational, or school functioning (few friends, conflicts with peers or co-workers). In accordance with Table 14.10 the score of 53 equates to 10%. On the PIRS the applicant's score was 4, in accordance with Table 14.17, which equates to 10%. Based on the median score of the three tests, Dr. Hasan assigned a 10% WPI. Also, as per the Guides, Dr. Hasan identified a diagnosis under the DSM-5-TR;

Adjustment Disorder with Mixed Anxiety and Depressed Mood, Persistent. I find Dr. Hasan's rating is persuasive because his report provides all supporting assessment responses and is internally consistent. Further, the responses indicated and diagnosis are consistent with the testimony of the applicant, Ms. Paulson, occupational therapist, and Amanda-Lee Gomes, registered social worker.

[37] I give little weight to Dr. Gilman's WPI rating of 40% because he rejects the use of the BPRS and PIRS and instead employed the "DSM-5 WHODAS 2.0 Standardized Interview to quantify the Interruption in Daily Functioning using equal interval measures." Further, Dr. Gilman opines that because the applicant sustained a brain injury (concussion), the 6th Ed of the Guides does not apply and instead the 4th Ed., must be used to determine his psychological impairment. I disagree with Dr. Gilman's interpretation.

[38] I agree that a physical brain injury is not included in the mental or behavioural impairment evaluation, according to s. 3.1.(1) 7. of the *Schedule*. A brain injury would be evaluated according to Chapter 4 of the 4th Ed., of the Guides as part of the nervous system evaluation under section 4.1b, c, and d., using Tables 2, 3, and 4. However, the *Schedule* has delineated the symptoms of a brain injury, from the psychological condition that results in mental or behavioural symptoms. Therefore, the requirement for a rating using Chapter 14, of the 6th Ed., methodology is required for the mental or behavioural component of criterion 7.

[39] I find that Dr. Gilman has not conducted an assessment in accordance with the *Schedule*, and therefore, I give little weight to his WPI rating of 40%.

Total WPI Combined Values

[40] For the reasons above, I find the applicant's physical WPI rating of 22%, combined with the mental and behavioural rating of 10% WPI, provides a Total Combined WPI rating under criterion 7 of 30%, which does not rise to the threshold of 55% WPI for a catastrophic impairment determination. Therefore, I find the applicant has

not proven on a balance of probabilities that he has sustained a catastrophic impairment under criterion 7 of the *Schedule*.

CRITERION 8

[41] I find the applicant has not suffered a mental or behavioural impairment that meets the threshold for a catastrophic impairment under Criterion 8 of the *Schedule*.

[42] In order to meet the threshold for a CAT impairment under Criterion 8, an individual must have sustained three marked (class 4) impairments out of the four spheres of functioning or one extreme (class 5) impairment as a result of the accident due to a mental and behavioural disorder. These impairments are assessed under Chapter 14 of the Guides 4th Ed. 1993. Mental and behavioural impairments are rated according to how seriously they affect a person's useful daily functioning. The Guides sets out the four spheres of functioning and the levels of impairment as outlined in the chart below.

Sphere of Functioning	**Class 1: No Impairment**	**Class 2: Mild Impairment**	**Class 3: Moderate Impairment**	**Class 4: Marked Impairment**	**Class 5: Extreme Impairment**
Activities of Daily Living (ADLs)	No impairment is noted	Impairment levels are compatible with most useful functioning	Impairment levels are compatible with some, but not all useful functioning	Impairment levels significantly impede useful functioning	Impairment levels preclude useful functioning
Social Functioning					
Concentration, Persistence and Pace (CPP)					
Adaptation					

[43] The applicant relies on the neurocognitive and psychological evaluations of Dr. Gilman, who rated the applicant as having class 4, marked impairments in the functional

spheres of ADLs, social function, and CPP, and a class 5 extreme impairment in the functional sphere of Adaptation (deterioration in a work-like setting). The applicant also relies on the in-home assessment conducted by Varun Madan, occupational therapist.

[44] The respondent relies on the psychiatric evaluation completed by Dr. Sidiq Hasan, psychiatrist, and the occupational therapy in-home and situational assessments conducted by Starr Robinson, occupational therapist. The respondent submits that the applicant has a class 3, moderate impairment in the functional spheres of ADLs, and social functioning, and a class 2, mild impairment in the sphere of CPP, and a class 4, marked impairment in the sphere of Adaptation. The respondent submits the applicant has not sustained a catastrophic impairment under criterion 8.

[45] The parties' ratings are summarized in the chart below:

Area or Aspect of Functioning	**Class 1: No Impairment**	**Class 2: Mild Impairment**	**Class 3: Moderate Impairment**	**Class 4: Marked Impairment**	**Class 5: Extreme Impairment**
ADLs			Respondent	Applicant	
Social Functioning			Respondent	Applicant	
CPP		Respondent		Applicant	
Adaptation				Respondent	Applicant

Activities of Daily Living ("ADLs")

[46] I find the applicant has sustained a class 3, moderate impairment in the sphere of ADLs.

[47] The Guides explain ADLs as follows:

> Activities of daily living include such activities as self-care, personal hygiene, communication, ambulation, travel, sexual function, sleep, social and recreational activities in the context of the individual's overall situation, the quality of these

> activities is judged by their independence, appropriateness, effectiveness and sustainability. It is necessary to define the extent to which the individual is capable of initiating and participating in these activities independent of supervision or direction. What is assessed is not simply the number of activities that are restricted, but the overall degree of restriction or combination of restrictions.

[48] Dr. Hasan rated the applicant as having a class 3; impairment compatible with some, but not all useful functioning. I find the report, and ratings of the applicant's limitations, of Dr. Hasan to be clear, and well grounded in examples provided by the applicant, as well as treatment providers, and Dr. Hasan's own clinical interview. I find this is consistent with the testimony I heard from the applicant, Ms. Gomes, and Ms. Paulsson. The applicant is independent in self-care and personal hygiene, albeit less frequently and at a slower pace compared to pre-accident activity. He occasionally needs assistance with heavier household chores, such as taking the garbage out. He cooks for himself on occasion, such as eggs or steak. He is fully independent with communication. His travel outside of the home is less frequent, sometimes due to environmental conditions, or motivation. He is independent with ambulation; however, he now uses a golf cart to access his property. Since the accident he has gone ice-skating with his kids, and has ridden a bicycle. The applicant's sexual function has decreased due to pain and depression however; he remains intimate with his partner. The applicant's sleep has also decreased due to pain, but has improved since he began using an adjustable bed. The applicant testified that he has re-engaged with motor sports, again, albeit on a less frequent basis than before the accident. I find that in its totality, the evidence strongly supports the applicant is capable of some, but not all useful functioning, and a class 3, moderate impairment is appropriate.

[49] I place less weight on Dr. Gilman's report and testimony because I find his rating of a class 4; impairment levels significantly impeding useful functioning, are not corroborated by the preponderance of the evidence. Dr. Gilman testified that he understood the applicant to be housebound, on the couch or a bed in the family room and entirely dependent on others for food and self-care. The only evidence I have before

me that would support this opinion is summarized in Dr. Gilman's report; The summarized report is a therapy initial assessment report by Maria Paulsson dated April 10, 2023, which was four days post left ankle fusion surgery. However, the orthopaedic surgeon's assessment report dated November 20, 2023, of Dr. Bruce Paitich, orthopaedic surgeon, which is also summarized in Dr. Gilman's report identifies that in April 2023 the applicant began attending a community gym, is walking unaided, and is independent with personal grooming and care tasks. At that time the applicant reported to Dr. Paitich that he feels capable of performing most domestic tasks within his home, using pacing strategies. The applicant's improved function post fusion surgery appears to have been ignored by Dr. Gilman in reaching his conclusions.

[50] I find Dr. Hasan's class 3, moderate impairment rating for the sphere of ADLs is appropriate.

Social Functioning

[51] I find the applicant has sustained a class 3, moderate impairment in the sphere of social functioning.

[52] The Guides explain social functioning as follows:

> An individual's capacity to interact appropriately and communicate effectively with other individuals. It includes the ability to get along with others such as family members, friends, neighbours, grocery clerks, lenders, etc. Impaired social functioning may be demonstrated by history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, social isolation, or similar events or characteristics. Strengths in social functioning may be documented by an individual's ability to initiate social contact with others, communicate clearly with others and interact and actively participate in group activities, cooperative behaviour, consideration for others, awareness of others' sensitivities and social maturity also need to be considered.

[53] Dr. Hasan rated the applicant as having a class 3; impairment compatible with some, but not all useful functioning. I find the report, and ratings of the applicant's limitations, of Dr. Hasan to be clear, and well grounded in examples provided by the applicant, as well as treatment providers, and Dr. Hasan's own clinical interview. I find this is consistent with the testimony I heard from the applicant, Ms. Gomes, and Ms. Paulsson. The applicant's social activities are partially decreased due to having relocated from Beeton to the Kawartha area in April 2025. The applicant remains in contact with some friends and family by telephone, social media, and occasional visits. He has lost some friendships, which he attributes to a change in his personality since the accident, but he has made new friends in his new community. His relationship with his partner has been strained and she has considered leaving, however he is motivated to improve the relationship and has been engaged in couples counselling as well as one-on-one therapy. He has re-engaged with some pre-accident leisure activities, such as motor sports, albeit lesser in frequency. He re-engaged with hunting in 2025. He engages with his children, and has been observed by the occupational therapy assessors to have positive and appropriate interactions, however his mood is volatile, being triggered by toys being left on the floor, or what he perceives to be unsafe situations. I agree with Dr. Hasan that these examples are indicative of a capacity for some reciprocal communication and interpersonal engagement, initiating and maintaining social interactions, but not all useful social functioning.

[54] I find the rating of class 4 impairment by Dr. Gilman is not persuasive because he testified that his conclusions are largely based on the collateral interview of the applicant's partner. The limited examples provided largely focus on the worst-case scenarios. Further, Dr. Gilman relies on the applicant having declined to participate in the situational task of attending a grocery store, and opined that this supports his functional limitations. However, I find Dr. Gilman's opinion is contradicted by the applicant's testimony, and reporting to other assessors that he is capable of, and does attend the store to purchase groceries. I am not persuaded that the applicant's true capacity for social functioning was considered by Dr. Gilman.

[55] I accept Dr. Hasan's rating of a class 3, moderate impairment in the sphere of social functioning.

Concentration, Persistence, and Pace (CPP)

[56] I find the applicant has sustained a class 2, mild impairment in the functional sphere of CPP.

[57] The Guides explain CPP as follows:

> Concentration, persistence and pace needed to perform many activities of daily living, including task completion. Task completion refers to the ability to sustain focused attention long enough to permit the timely completion of tasks commonly found in activities of daily living or work settings Strengths and weaknesses in mental concentration may be described in terms of frequency of errors, the time it takes to complete the task and the extent to which assistance is required to complete the task.

[58] Dr. Hasan rated the applicant as having a class 2; mild impairment compatible with most, useful functioning. I find the report, and ratings of the applicant's limitations, of Dr. Hasan to be clear, and well grounded in examples provided by the applicant, as well as treatment providers, and Dr. Hasan's own clinical interview. I find this is consistent with the testimony I heard from the applicant, Ms. Gomes, and Ms. Paulsson. Dr. Hasan relies on the results of the Montreal Cognitive Assessment (MoCA) test administered by Starr Robinson, occupational therapist, in which the applicant scored 26/30, representing normal cognitive function.

[59] I find this is consistent with the cognitive tests administered by Varun Madan, occupational therapist: The applicant completed the Trail Making Test, which is conducted to assess the client's cognitive skills, impairments and task performance. Part A was completed in 19.9 seconds (deficient results would exceed the cut-off time 78 seconds). Part B was completed in 222.1 seconds (deficient results would exceed the cut-off time 273 seconds). The applicant's error rate was not noted in Mr. Madan's

report. The applicant had also completed the Mental Calculations Test, and answered 6 of 7 mental math questions correctly. The applicant also completed a Contextual Memory Test, with an immediate recall score of 13/20 and a delayed recall score of 15/20, which were both within normal limits. The applicant had also undergone significant neuropsychological testing with Dr. Christopher Hope, neuropsychologist, and Dr. Gilman. The applicant's test results ranged from low-average to exceptionally high, demonstrating normal cognitive function. Additionally, many of the assessment reports speak to the applicant's ability to remain focused and participate in the process, lasting several hours at a time. I find the corroborating cognitive test results support Dr. Hasan's conclusion and rating.

[60] I also find Dr. Hasan's rating persuasive because he does consider that the applicant experiences occasional or situational difficulties with concentration, particularly in the context of pain, emotional distress, or external stressors. However, Dr. Hasan concludes, and I agree, that the objective screening measures and clinical observations support that applicant's level of impairment is compatible with most useful functioning.

[61] I find Dr. Gilman's report attracts little weight, as I am not persuaded by Dr. Gilman's class 4 rating and report in which he concludes that the applicant has sustained a post traumatic brain injury that included significant losses in Verbal Intelligence, Auditory Memory, Working Memory, and Processing Speed, which significantly compromised the applicant's concentration and pace. I find the psychometric test results on which Dr. Gilman relied do not support an impairment in cognitive function because the results were between average and high-average, with a Full Scale IQ 112. Further, the applicant's memory scores ranked average to high-average. Dr. Gilman did not provide real world examples on which he relied to determine an impairment in CPP. Instead, Dr. Gilman focused on the applicant's use of crutches between February and March 2023, as the reason the applicant could not supervise his three employees, and therefore had to close his window washing business. I find the evidence on which Dr. Gilman relies does not support his rating because it does not demonstrate limitations in the applicant's ability to concentrate on, persist with, or pace activities.

[62] I find the applicant has sustained a class 2, mild impairment in the functional sphere of CPP.

Adaptation

[63] I find the applicant has sustained a class 4, marked impairment in the sphere of adaptation to a work, or work-like setting.

[64] The Guides explain adaptation as follows:

> Deterioration or decompensation in work or work-like settings refers to repeated failure to adapt to stressful circumstances. In the face of such circumstances the individual may withdraw from the situation or experience exacerbation signs and symptoms. He or she may decompensate and have difficulty maintaining activities of daily living, continuing social relationships and completing tasks. Stressors common to the environment include attendance, making decisions, scheduling, completing tasks and interacting with others.

[65] Dr. Hasan rated the applicant as having a class 4; marked impairment significantly impeding useful function. I find the report, and ratings of the applicant's limitations, of Dr. Hasan to be clear, and well grounded in examples provided by the applicant, as well as treatment providers, and Dr. Hasan's own clinical interview. I find this is consistent with the testimony I heard from the applicant, Ms. Gomes, and Ms. Paulsson. The evidence corroborates that the applicant has an impaired stress tolerance, and experiences emotional dysregulation and maladaptive coping strategies, including excessive alcohol consumption. I find that in terms of a work-like setting, emotional deterioration that leads to inappropriate behaviour would significantly impede useful function because it would interfere with interpersonal relationships with colleagues, supervisors, and customers, as well as impede appropriate decision-making, and engagement. I agree with Dr. Hasan's rating of a marked impairment in functional adaptation.

[66] I find Dr. Gilman's conclusion and rating attract little weight because he concluded that the applicant being unable to supervise his employees, due to his physical injury, caused psychological distress and an inability to cope, requiring him to withdraw from the workplace. From his report(s), it appears that Dr. Gilman was unaware that the applicant had continued to operate his business in April – November 2023, and April – November 2024. The income tax records support that the business was more profitable post accident. The applicant testified that he had to close the business because he could not do the labour, and he could not find reliable employees. Additionally, the applicant moved in April 2025, from Beeton, where he had operated his business for 18 years, to the Kawartha area, approximately two hours away from his former clientele. I find Dr. Gilman's conclusions and rating of a class 5, extreme impairment that precludes useful functioning is unsupported by the evidence because the applicant demonstrated useful function when he continued operation of the business until 2025, when he relocated his family.

[67] I find Dr. Hasan's rating of a class 4, marked impairment in the functional sphere of adaptation is appropriate.

[68] I find the applicant has not sustained a class 4, marked impairment in at least three spheres of functions, nor a class 5, extreme impairment in any one of the spheres of function, and therefore, the applicant has not proven on a balance of probabilities that he has sustained a catastrophic impairment under criterion 8 of the *Schedule*.

INCOME REPLACEMENT BENEFIT ("IRB")

[69] I find the applicant is not entitled to income replacement benefits from March 31, 2025, to date and ongoing.

[70] The parties agree that the applicant was entitled to and received IRBs up until March 31, 2025. The issue in dispute is ongoing entitlement to post-104-week IRB.

[71] To receive payment for a post-104-week IRB under s. 6 of the *Schedule*, the applicant must demonstrate on a balance of probabilities that they suffer from a

complete inability to engage in any employment or self-employment for which they are reasonably suited by education, training or experience.

[72] The applicant submits that due to his Adjustment Disorder, he is unable to work, and the respondent's psychiatrist, Dr. Hasan agreed.

[73] The respondent submits that the IE assessments support that the applicant does not have a complete inability to engage in any employment or self-employment for which he is reasonably suited by education, training or experience.

[74] The physiatry assessment conducted on March 31, 2025, by Dr. Ismail, identified the applicant as having the physical ability for limited to light physical strength classification employment, requiring sitting or a combination of sitting, walking and standing. Dr. Ismail noted that the functional capacity evaluation on April 14, 2025, conducted by Vincent Yip, physiotherapist resulted in a "voluntarily demonstrated" abilities within the Medium Physical Demands Characteristic Level. Dr. Ismail opined that the applicant does have the ability to engage in employment, for which he is reasonably suited by education, training or experience. I find Dr. Ismail's conclusion persuasive from a physical perspective because he does take into consideration the applicant's college education, training, and experience operating a business.

[75] The psychological assessment conducted on April 14, 2025, by Dr. Tatiana Dumitrascu, psychologist identified the applicant's experience with scheduling work, and hiring employees. Her mental status observations were that he had no difficulties with concentration and memory, and his mood was calm. Although he became emotional when talking about the accident and post-accident difficulties, he was able to recompose himself quickly. I find Dr. Dumitrascu's opinion persuasive because she details the applicant's complaints, and psychological testing result, which she found to be consistent with his clinical presentation. Her opinion was that his symptoms of anxiety and depression were mild at the time of the assessment, and her diagnosis was Adjustment Disorder with Mixed Anxiety and Depressed Mood. Dr. Dumitrascu further opined that his prognosis is fair considering his mild symptoms and that he is very

motivated in his recovery. Her conclusion was consistent with her objective findings, in that the applicant does not have any psychological restrictions from engaging in employment activities, such as those identified by the Vocational Evaluation.

[76] The vocational evaluation conducted on March 10, 2025, by Diamantis Zervas, certified vocational evaluator identified the applicant's experience as follows: Management of the daily business operations including: calling past customers to book them for upcoming season and/or additional requests; ensuring all tools and equipment available; provision of supervision and delegation of tasks; booking clients and setting up weekly schedule; accounts payable including banking; training new employees. Job site attendance to check the scope of work and/or provide quote(s) of services. Also handling invoicing and addressing customer service issues; and/or handling of any complaints. Attend job sites and provide directions to workers on how to organize the work and strategize. Proficiency with the internet and email operations, and basic knowledge with Microsoft Word and Excel programs. Based on his qualification and assessed aptitude, several potential employment positions were identified, for example as a scheduler/coordinator within the same industry, which I find supports that there are employment positions for which the applicant is reasonably suited based on his current abilities.

[77] The applicant has directed me to the IE psychiatric CAT assessment report of Dr. Hasan in support of the applicant's complete inability to engage in any employment. The applicant submits that Dr. Hasan's rating on the PIRS, Table 14-16 Resilience and Employability, demonstrates the doctor's opinion that the applicant has a "Severe impairment. Cannot sustain work over time in any position." The applicant further submits that the respondent ignored Dr. Hasan's opinion and withheld the IRB. I agree with the applicant that Dr. Hasan did give a rating of 4, or severe, on Table 14-16. However, I give this rating little weight because it is a singular indication of the applicant's work capacity that is not supported by an explanation or clarification as to why it was selected, or on what basis the rating was given. Also, it is one of six ratings within the PIRS, the remaining five being rated as 2s. Further, this rating bears no connection with the legal test for post-104-week IRB, based on education, training and

experience, and is not corroborated by other assessors, or evidence of the applicant's post-accident employment history, to which I have been directed.

[78] I find that the applicant has not proven on a balance of probabilities that he is entitled to post-104-week IRB.

ATTENDANT CARE BENEFIT ("ACB")

[79] I find that the applicant is not entitled to ACBs from June 18, 2025, to date and ongoing because he has not proven that it has been incurred.

[80] Section 19 of the *Schedule* states that an insurer shall pay for all reasonable and necessary expenses incurred by or on behalf of an insured person for attendant care services provided by an aide or attendant, as a result of an accident.

[81] Further, the amount of a monthly ACB is determined in accordance with the approved version of the document entitled Assessment of Attendant Care Needs ("Form 1") that is required to be submitted under s. 42 and is calculated by (a) multiplying the total number of hours per month of each type of attendant care listed in the document that the insured person requires by an hourly rate, that does not exceed the maximum hourly rate, as established under the Professional Services Guideline 03/14 (the "Guideline"), that is payable in respect of that type of care, and (b) adding the amounts determined under clause (a), if more than one type of attendant care is required.

[82] The maximum payable for ACB under the *Schedule* is $3,000.00 per month for non-catastrophically impaired insureds, and $6,000.00 per month for insured persons who have been determined to be catastrophically impaired.

[83] Section 3(7)(e) of the *Schedule* provides that expenses are not incurred by an insured person unless: (i) they have received the goods or services to which the expense relates; (ii) they have paid the expense, have promised to pay the expense, or are otherwise legally obligated to pay the expense; and (iii) the person who provided the goods or services (a) did so in the course of the employment, occupation, or profession

in which he or she would ordinarily have been engaged, but for the accident, or (b) sustained an economic loss as a result of providing the goods or services to the insured person.

[84] The applicant did not make submissions, nor was I directed to evidence that corroborates the applicant incurred attendant care expenses from June 18, 2025, to date.

[85] The respondent submits that the IE for attendant care concluded that there is no entitlement. The respondent relies on the Physiatry assessment of Dr. Farooq Ismail, physiatrist, and Jeff Perrier, occupational therapist.

[86] The applicant did not point to or direct me to evidence to corroborate that attendant care is reasonable and necessary, and therefore I find that the applicant has not proven that attendant care benefits are owing.

[87] I find the applicant has not proven on a balance of probabilities that he is entitled to attendant care benefits from June 18, 2025, to date and ongoing.

TREATMENT PLANS

[88] The parties agree that the applicant has exhausted the non-CAT medical and rehabilitation benefits funding limit of $65,000.00. Having found that the applicant is not catastrophically impaired, there are no further medical and rehabilitation benefits available to the applicant. Therefore, it is not necessary for me to consider if the treatment plans are reasonable and necessary.

AWARD

[89] I find no award is owing.

[90] Under s. 10 of O. Reg. 664, the Tribunal may award up to 50% of the total benefits payable if it determines that the insurer unreasonably withheld or delayed the

payment of benefits. The case law is well established that in determining whether an insurer's conduct in withholding or denying a benefit warrants an award, an insurer's behaviour must be seen as "excessive, imprudent, stubborn, inflexible, unyielding, or immoderate." An award should be proportionate and considerate of the blameworthiness of the insurer, the vulnerability of the insured and the advantage wrongfully gained by the insurer from its misconduct.

[91] The applicant submits that the respondent ignored the opinion of its own assessor, Dr. Hasan, and the conduct is grounds for an award.

[92] The respondent did not make submissions regarding the applicant's claim for an award.

[93] Having found that the applicant is not entitled to IRB, and for the reasons stated in para 77 above, I disagree that the respondent ignored the opinion of Dr. Hasan. It follows that the respondent has not acted in a manner that attracts an award under s. 10 of Reg 664.

[94] I find the applicant has not proven on a balance of probabilities that the respondent unreasonably withheld or delayed the payment of benefits.

INTEREST

[95] As there is no overdue payment of benefits, the applicant is not entitled to interest pursuant to s. 51 of the *Schedule*.

ORDER

[96] For the reasons above, I find:

1. The applicant has not sustained a catastrophic impairment as defined by the *Schedule*.

2. The applicant is not entitled to an income replacement benefit.

3. The applicant is not entitled to attendant care benefits.

4. The applicant is not entitled to the treatment plans in dispute.

5. No award or interest is owing.

Released: August 27, 2026

Tami Cogan
Member